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ABSTRACT

A program to teach basic social skills to institutionalized severely retarded adults began with identification of those social behaviors that were most desirable and realistic. Following development of the Basic Social Skills Inventory, specific training suggestions were developed for each step of the scale. The program was field tested with two experimental and one control group of residents 16 to 50 years old. The inventory was found to be reliable and the program was found to produce significantly more new socialization skills than the control program. A highly motivated university student worked from a training manual but did not need an orientation or workshop to conduct the program. His comments describing his group and the progress they made in social skills concludes the paper. (CL)

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TEACHING SOCIALLY APPROPRIATE BEHAVIOR TO ADULT, INSTITUTIONALIZED, SEVERELY RETARDED PEOPLE

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In a time of increased emphasis on "deinstitutionalization" and "normalization", appropriate social behavior is as important for retarded people as are self-care and other skills. Yet the proliferation of training manuals have much to say about teaching eating, dressing, toileting, and basic cognitive skills, but little if anything to say about teaching socialization skills. When socialization is mentioned, it is in one of two contexts. Sometimes it is suggested that socialization be taught as part of the total program through normalization and community exposure...but HOW to carry out this training is not included. The second context suggested for teaching socialization is that of normal infant development. These are realistic when applied to retarded children who are raised within their families. They will learn socially appropriate behavior, showing the same range in personality and behavior as non-retarded children. Their parents and teachers will incorporate socialization training into the daily routine, ideally having expectations appropriate to each retarded person's developmental age.

When the focus becomes adolescent and adult severely retarded people with long-term institutionalization, socialization assessments and training programs based on infant development are inappropriate for two reasons. First, the institutional environment itself shapes interpersonal and environmental responses such that many early developmental responses have been shaped out of the person's repertoire (e.g., after years of being surrounded by noise, the institutionalized person's adaptive behavior is seen in learned ignoring of most sounds). Second, many infant and child behaviors are inappropriate for adolescents and adults (e.g., playing "peek-a-boo", an early developmental goal in social interaction).

The Basic Social Skills Inventory (BSSI) and Training Program (BSSTP) is our attempt to meet the need for an age-appropriate method to teach the most basic social skills to institutionalized, severely retarded adolescents and adults. The first part of this paper briefly describes the Basic Social Skills Program and then describes the procedure used to determine its effectiveness. Part II gives a more specific picture of the type of person for whom this program was developed and of the training sessions.

I

Development of the Basic Social Skills Program

The first step was to identify those social behaviors which were most desirable and also realistic (upward extensions are always possible). These social behaviors were then task analyzed and divided into separate scales:

1. Appropriate physical interaction
2. Touching/manipulating objects
3. Reacts to name
4. Social smiling
5. Eye contact
6. Social interaction with trainer
7. Traveling with trainer
8. Group interaction
9. Development of leisure skills
10. Waiting/sharing/taking turns

Each scale describes a series of increasingly complex and socially demanding tasks with instructions for assessment and criteria for competence. While skills from some scales are pre-requisite to skills on other scales, there are no pre-requisites to the program as a whole. Thus, the program is applicable to people at even the most primitive levels of behavior.

Specific training suggestions have been developed for each step of each scale. The exclusive use of positive reinforcement encourages the development of good feeling between the student and the trainer which further encourages socialization.

Procedure for Determining Effectiveness of the Program

We had three questions in mind as we planned a procedure for determining the effectiveness of the Basic Social Skills Inventory and Training Program. First, would this program in fact be effective with a severely retarded, institutional population? The second question relates to the efficacy of assuming that socialization training will take place as part of a total training program. Would specific socialization training using this program result in greater social behavior change by institutional residents than a total training program? The third question arose as a result of the observation that a new program which requires implementation or even orientation in its use by the people who developed it has limited potential. Could this program be implemented successfully by someone whose only contact with it was through a written manual?

One control group and two experimental groups were used in the procedure designed to answer the above three questions. The control group was taught by a teacher, certified to teach students who are mentally retarded, whose curriculum was independent of this project but which included socialization as part of a total training program. One experimental group participated in the Basic Social Skills Program under the direction of a teacher involved in its development. Both of these groups were taught in a school setting. The second experimental group participated in the program under the direction of a psychology student who was hired for the summer to work in a state institution. He was given a written copy of the program, a group of students, $10 worth of materials, and a small room on a ward. Each of the three groups consisted of six to eight students sixteen to fifty years of age, matched

for level of functioning in language and skills and for appropriateness of behavior. (Examples of initial behavior: "A" crouched in a corner; when trainer approached, she would run or hit out. "D" ignored people and threw objects. More detailed descriptions of behavior will be given in the second part of this paper.) The students in all three groups resided in a state institution.

Two experienced assessors scored all twenty-one students on the skills using the BSSI and on the Socialization Scale of the Progress Assessment Chart (PAC--being used at the time by the Michigan Department of Mental Health). The latter was used as an independent check on social skills. These assessors were not familiar with the experimental design. After independent assessments to determine reliability, they conferred on all differences of opinion and arrived at a concensus. Assessment results were not conveyed to the trainers, who did their own assessments as part of the Basic Social Skills Program.

Each group then received two hours of instruction each weekday for five weeks. The control group received its teacher's regular instructional program while the two experimental groups received the BSSTP.

The same two assessors, still unfamiliar with the experimental design, again assessed all twenty-one students, using the same procedure as before. They did not have access to their earlier results at this time.

Results

We found inter-rater reliability for the two assessors ranging from 80% to 100%. Our criteria for effectivensss was an increase in the number of new

socialization skills demonstrated by the students. The average number of new socialization skills as measured by the BSSI was one per student for the control group, fifteen per student for the experimental group taught by the program developer, and sixteen per student for the experimental group taught by the person using the written manual. The average number of new socialization skills as measured by the PAC was two per student for the control group and six and nine per student, for the two experimental groups respectively.

Since the assessment items of the BSSI are meant to be a guide for training and not an equal interval scale and since we make no claim to standardization of the assessment, further statistical analysis would be meaningless. Based on the average gain per student and the descriptive material in the second section of this report, our answers to the three questions we asked concerning effectiveness of the Basic Social Skills Program are as follow:

1. The Basic Social Skills Program was in fact effective in increasing socially appropriate behavior of a severely retarded, institutional population.
2. More socially appropriate behavior was learned when it was specifically taught than when it was assumed within a total program.
3. The Basic Social Skills Program was used effectively by a highly motivated university student who worked from the training manual without an orientation or workshop.

We assume that other professionals in the field of mental retardation could effectively use this program. Our next interest is to explore the possibilities for use of the Basic Social Skills Program by ward attendants and other paraprofessionals in the field.

The university student, not known to or by the program developers prior to the research, wrote this section at its conclusion.

II

A discussion of what was involved in actually conducting the program covers three main areas:

1) What were our students like at the beginning of the program, and what criteria were used in selecting them? How did their social abilities change during the program's five weeks?
2) What techniques were employed in bringing about these changes? How was the program applied to the group as a whole, and how was it adapted to the needs and personalities of individual students?
3) What were our roles as therapists/trainers/friends in working with the students? What sorts of trainer-student relationships were involved in shaping new interpersonal skills? These issues are, of course, interrelated, as will become evident in the discussion.

The Participants

Basically, our group consisted of six severely retarded, institutionalized adults who significantly lacked social skills. Our students could all be characterized in terms of "institutional syndrome", familiar to those of us who have worked in an institutional setting. Having passed so many years (more than twenty, in most cases) with little directed and continued contact with others, these people had adapted social isolation as a way of life. They did not seem interested in activities around them and either ignored or actively avoided others. They passed their time isolated and undisturbed, cooperating with attendant staff and other residents only in such daily necessities as being dressed, fed, washed, and toileted. But then, as much

of this individual attention tended to be of an unpleasant nature, it is not surprising that they preferred to attract as little of it as possible.

The participants were selected during a week in which the trainers visited and observed several wards and activity centers. We noted those who seemed to be most severely retarded socially, talked with the attendants who knew them best, and consulted their files regarding the duration of their institutionalization and the history of their particular problems. We assessed several of these residents with the primary level of the P.A.C. and chose as the final group those who scored as the least "socially developed." A brief description of three of the group provides a sense of the severity of their social difficulties.

Richard was a 51 year old veteran of the institution, admitted at age 12, and having lived in the same ward for the past several years. We first spotted him sitting and rocking alone in the corner of the day room where he always sat, head down, eyes closed, and arms folded across his chest. He refused to look up when addressed and only acknowledged us by angrily babbling when we persisted in speaking to him. Richard rarely performed any individual actions of his own, but walked along with the rest of his ward for meals and activity times. At the beginning of the program, Richard determinedly refused to participate in any sorts of activities or games, refused all social reinforcers, and spit out edibles.

Annie was a 35 year old woman who had been in the institution since age 15. She did not passively ignore interactions with others as did Richard, but instead either actively avoided or aggressed against them. Few of the people who lived or worked with her had not been scratched or

struck at one time or another. In fact, we witnessed her slashing another resident with a piece of broken glass during our first observation. Most of the time, though, she would run from anyone who approached her, preferring to crouch in corners or beneath tables with her sweatshirt pulled completely over her head and her arms folded inside. From this defensive position she would peer cautiously out and scream threateningly at nearby others. Not surprisingly, it was nearly impossible to get her to go to the program area at all, let alone actively participate with others.

Alex was a very reticent, yet relatively charming 36 year old man who had lived in the institution since age 14. His was clearly a case of more social than mental retardation. Though it took quite a while, we came to find Alex capable of expressing himself verbally and even able to read and write at low levels. But these skills were neither used nor required in his daily life, and Alex much preferred sitting alone and avoiding the attentions of others whenever possible. He was occasionally willing to play a game of catch with attendant staff, but usually he just sat -- eyes focused on the floor and hands folded in his lap -- away from the other residents, for hours on end. Only rarely would he walk about on his own and usually needed to be either slowly pushed or pulled along by another resident whenever the ward residents moved around as a group. Alex was very anxious during the initial training sessions, and refused even to acknowledge us. During these periods, he sat unmoving, his head only inches from the table top, until he was returned to his building.

The three other members of the adult group in their own ways ignored or resisted most social contacts just as strongly and thus established a rather formidable beginning for the program.

Training Techniques

The six residents were divided into two groups of three, each of whom worked together for 1½ - 2 hours a day, five days a week, for five weeks. Again, the beginning sessions were spent in simply getting the residents to come with us to the training area, and in familiarizing them with the setting, with the trainers, and with one another. Once we were able to establish a semblance of routine, most sessions involved a combination of group-oriented and more individualized activities. We would often begin, for example, by seating the group in a circle and enthusiastically encouraging them to toss a ball among themselves, pass some small item around the circle, or work together on a puzzle. Following this, we would seat the group at a large table and work with one at a time on particular tasks, while the others waited their respective turns.

The type of individual goals we focused on for each person depended first upon the individual assessment results, and as training progressed, the goals outlined in the B S S T P manual. The program describes a gradual, systematic sequence of skills beginning with the most basic skill in each of ten areas. We shaped behaviors according to each person's level of social development in those sequences. For example, Richard was reinforced in the beginning just for looking up when spoken to, while others were encouraged to choose their own favorite toys, or to smile and shake hands

with a puppet, with the trainer, and with other members of the group. Each student's progress was marked on two kinds of daily records: 1) a narrative summary of the session describing which goals were trained, the techniques employed, and the person's mood and efforts, and (2) a quantitative measure of the daily percentage of successful training trials on particular tasks -- e.g., "80% proficiency" was required before moving on to the next goal in the sequence.

Trainer-Student Relationships

Just as important as the systematic and directed training of specific social behaviors was the friendly atmosphere of positive reinforcement in which the training took place. The key to the students' participation was their willingness to work with the trainers as friends, realizing that all sorts of pleasant rewards would come as a result of their cooperation. What began as a few simple and discrete rewards for specific social actions gradually generalized to the entire training environment. Student-trainer cooperation eventually became reinforcing in itself, although edible rewards continued to be given. But the greatest challenge was to determine just what sorts of rewards would most effectively establish the cooperative bond -- what would it take to get over the positive reinforcement "hump"?

As the relationship between each student and trainer was a highly individual matter, the types of reinforcements which established and maintained the relationships had to be especially suited to each case. But, as any form of prolonged social attention tended to be aversive and even

punishing in the beginning, "especially suiting" the reinforcements called for methods whereby the trainers could gradually acquire the positive properties of other desired goods. For some, this meant initially relying heavily upon favorite edible rewards, and gradually fading them out as social praise and physical contact were faded in. For example, Annie, in the beginning, would have nothing to do with the trainers until she came to see them as a source of the green apples she enjoyed so much. After a few weeks, she would happily stroll hand-in-hand with us to the work area, and receive a green apple upon arriving. Finding a good initial reinforcement for Richard was more difficult. Not only did he reject all social attention, he refused every conceivable edible reward, from coffee to raisins to Rye Krisp. We found that what Richard liked most was to leave the setting and return to his ward, so we established a contingency between his cooperating on the most basic tasks -- such as shaking hands or tossing a ball -- and being permitted to return to his building. The number of required tasks was gradually increased until he was ultimately willing to participate for the entire session, so long as he was permitted to go home at its end. Short walks away from the work area were also reinforcing, and Richard eventually "discovered" a taste for a number of edible rewards.

The program emphasized the development of positive social behaviors above the elimination of undesirable ones. Thus, only positive techniques were employed. For the most part, the frequency of negative behaviors decreased without being directly dealt with, anyway. Negative behaviors were either ignored or followed by a response cost procedure. Annie

was not directly addressed when removing her clothes and throwing them about the room. She was either ignored until putting them back on or was treated as impersonally as possible as they were placed back on her. When Richard refused to join the others at the table, it just meant that he missed out on an opportunity to receive desired rewards (although he was strongly encouraged to participate).

In the end, the number and type of "new social skills" each person developed were limited at best. We saw no miracles. Still, as the formal assessments found, some very positive changes were made and, informally, even the attendant staff noticed and encouraged them in daily activities. For Richard, this meant a willingness to participate in such group activities as playing catch, shaking hands with several other residents, and working with his trainers on small building kits and puzzles. He never did develop consistent eye contact, but he was able to look up at others with interest. Annie's progress was not "constructively positive" so much as "less negative." Only on rare occasions would she sit near the trainers or other residents, and she consistently shunned group activities. But she did learn to come out of her corner, no longer hid beneath the table, and was comfortable enough in the setting to watch the activities of others while neither running from nor aggressing against them. Alex showed a slow but steady "opening up" process. He was eventually able to sit up, smile frequently, run outdoors with the rest of the group, participate in individual and group activities, and read and write with little social inhibition. In fact, one of the program's brightest

moments came when he looked up one day and quietly said, "I like you."

NOTE: Since presentation of this paper, The Basic Social Skills Inventory and Training Program has been published by Research Press (Champaign, Illinois) under the title, Social Skills for Severely Retarded Adults.